BadgerCare+ Basic Plan

You will find the following information in this booklet. If you have questions, before you contact Basic Customer Services, please read this booklet. You may find your answer.

- Premiums
- Enrollment Letters
- Alternatives to BadgerCare Plus Basic Plan
- Enrollment in Other Programs
- Other Health Insurance Coverage
- Basic Plan Rules
- Your Rights
- ForwardHealth Basic Plan Card
- Core Plan Waitlist
- Benefits and Copays

The Basic Plan is a limited benefits health care plan for members who are on the Core Plan waitlist. Taking part in the Basic Plan does not affect your status on the Core Plan waitlist.

Basic Plan members can see any provider taking part in BadgerCare Plus. To see if your provider is a BadgerCare Plus provider or to find a provider, call Member Services at 1-800-362-3002.

You can stay enrolled in the Basic Plan as long as you pay your monthly premium and stay on the Core Plan Waitlist and meet all Core Plan rules. To meet the Core Plan rules, you must be

- Living in Wisconsin,
- Age 19 through 64, and
- A U.S. citizen or legal immigrant.

Also, you must not:

- Have dependent children under age 19 living with you,
- Be pregnant,
- Have income above the program income limits at or below 200% of the Federal Poverty Level,
- Have private health insurance coverage when you request Core Plan coverage or in the 12 months before that date unless you lost your health insurance coverage for a good cause reason,
- Be able to sign up for insurance from an employer during the month you apply or next three months,
- Have had access to health insurance through an employer in the last 12 months,
- Be disabled or blind and able to get Medicare, and
- Be able to get Medicaid or BadgerCare Plus for Families.

PREMIUMS

All members must pay a monthly $325 premium, per person, to stay enrolled in the Basic Plan. Premiums may change, based on the costs of the plan. You will be notified in advance of any premium changes.

Ongoing Monthly Premiums — Each month, you will get a premium payment slip in the mail. Your premium is due by the 5th of each month for coverage the next month.

These premiums can be paid:

Online with a credit card (MasterCard, Visa, or Discover), debit card or electronic check. To pay online, go to access.wi.gov and login to your MyACCESS page. On your MyACCESS page, click the button next to the "BadgerCare Plus Basic Plan" in the "My Applications Section."

By phone with a credit card (MasterCard, Visa or Discover), debit card or electronic check. To pay by phone, call Basic Customer Services at 1-800-291-2002. For faster service, please have your account number ready.

By mail with a personal check, money order, cashier's check or certified check. To pay by mail, please use a payment slip and send your payment to:

BadgerCare Plus Basic Plan
P.O. Box 6590
Madison, WI 53716

Please Note: To see all your past premium payments, you will need to use the same MyACCESS User ID and Password that you created when you signed up for the Basic Plan.

You must include the premium payment slip you get each month with your payment. If you lose your premium slip, you can go to access.wi.gov and print one. If you print the slip from your MyACCESS account, you must be sure to include your seven digit account number in the space provided on the slip. This number can be found on your enrollment letter.

Late Payment/No Payment — To stay enrolled in the Basic Plan; you must pay the full premium amount by the due date on the payment slip.

Note: If your payment is not received in full by the due date, your coverage will end.

There are no appeal rights for non-covered services. You should always check with your health care provider to see if a service is covered.

Alternatives to the Basic Plan

Before enrolling in the BadgerCare Plus Basic Plan, you should consider two other insurance options available to some Wisconsin residents. Enrolling in BadgerCare Plus Basic will make you ineligible for coverage under the Federal Pool option described below.

Option 1: Health Insurance Risk-Sharing Plan (HIRSP)

You may qualify for HIRSP if:

1. You recently lost your employer-sponsored insurance coverage; or
2. You have been rejected for coverage in the private insurance market; or
3. You have HIV/AIDS; or
4. You have Medicare because of a disability.

HIRSP offers comprehensive medical and pharmacy benefits including coverage of brand name drugs and $150 of first dollar coverage on routine/preventive services. HIRSP will not cover medical services for a preexisting condition for the first six months of coverage. The preexisting condition waiting period does not apply to drug coverage. The medical services preexisting condition waiting period does not apply if you qualify for HIRSP because you have recently lost your employer-sponsored coverage.

If your annual household income is below $33,000, you may be entitled to a premium and deductible subsidy. For example, a 25 year old man with an annual income of less than $10,000 would pay $89 per month for a $2,500 deductible insurance plan.

HIRSP members can also be enrolled in the BadgerCare Plus Basic or Core Plan.

For more information about HIRSP please contact HIRSP Customer Service at 1-800-828-4777 or visit http://www.hirsp.org/ (exit DHS).

Option 2: Federal Temporary High Risk Insurance Pool

You may qualify for the new Federal Pool if:

1. You are a citizen or national of the United States, or are lawfully present;
2. You have a preexisting medical condition; and
3. You have been uninsured for at least 6 months before applying for coverage.

The Federal Pool offers the same medical and drug benefits as HIRSP. There is no preexisting condition waiting period under the Federal Pool.

In most cases, the Federal Pool premium will be lower than the HIRSP premium.

For more information about the HIRSP Federal Plan, please contact HIRSP Federal Plan Customer Service at http://www.hirsp.org/plans/federal-eligibility.shtml (exit DHS) or call 1-888-253-2698.

Enrollment in Other Programs

Some Basic Plan members may be able to enroll in other programs. Those programs are the following:

COBRA: The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided

by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost of the plan. For more information, visit http://www.dol.gov/ebsa/cobra.html.

Health Coverage Tax Credit (HCTC): This program is available for individuals eligible for the Trade Adjustment Assistance (TAA), Alternative TAA, and Reemployment TAA benefit who also receive a Trade Adjustment Allowance or Unemployment Insurance. For more details, visit http://www.irs.gov/individuals/article/0,,id=187948,00.html.

Family Planning Only Services: Members who are enrolled in the Basic Plan may also be able to enroll in Family Planning Only Services. This program provides certain family planning services to stop unplanned pregnancies and sexually transmitted diseases (STDs). To learn more about this plan, go to dhs.wi.gov/em/CustomerHelp.

FoodShare: Members enrolled in the Basic Plan may also be able to enroll in the FoodShare program. This program helps people with limited money buy the food they need for good health. Benefits come on a plastic card that you use like a credit or debit card. To learn more about this program, go to dhs.wi.gov/em/CustomerHelp.

Wisconsin Well Woman Program: Women between the ages of 45-64 who are enrolled in the Basic Plan may also be able to enroll in the Wisconsin Well Woman Program (WWWP). The WWWP pays for mammograms and pap tests. For more details on this program, please call (608) 266-8311 or go to dhs.wisconsin.gov/womenshealth/wwwp.

Wisconsin Chronic Disease Program: Wisconsin Chronic Disease Program (WCDP) provides payment to health care providers for disease-related services for individuals with chronic renal disease, adult cystic fibrosis and hemophilia. Members may participate in both WCDP and the Basic Plan while paying a cost-share for both programs. For more information, call 1-800-362-3002 or go to dhs.wi.gov.

Wisconsin AIDS/HIV Drug Assistance Program (ADAP): ADAP is a program to provide Wisconsin residents access to HIV-related antiretroviral drugs and prophylactic medications as well as certain vaccines for hepatitis. For more information, go to dhs.wisconsin.gov/aids-hiv or call 800-991-5532.

Please Note: As of January 1, 2010, Wisconsin law allows some young adults under the age of 27 to be covered under his/her parents' health insurance even if the adult child is not a full time student. For more information, go to http://oci.wi.gov/ or contact the employer's Human Resources office.

Other Health Insurance Coverage

If you get health insurance coverage through your (or your spouse's) employer or you buy health insurance from an insurance company, you cannot stay enrolled in the Basic Plan. You must report this information by calling 1-800-291-2002.

"Health insurance coverage" does not include Family Planning Only Services, HIRSP, Well Woman Medicaid, Chronic Disease Program or Wisconsin AIDS/HIV Drug Assistance Program. If you are not sure the plan you have needs to be reported, contact Basic Customer Services at 1-800-291-2002 and ask if your health insurance plan needs to be reported.

Accident and Injury Claims

If you are in an accident or injured and you get a cash award or settlement due to the accident or injury and the Basic Plan pays for part or all of your care, you must report this to one of the following agency. If you have hired an attorney or are working with an insurance agency to settle your claim, you must report this information.

1. If you live in Clark, Douglas, Eau Claire, Fond du Lac, Green Lake, Juneau, LaCrosse, Lincoln, Marinette, Rock, Sheboygan, Trempealeau, Vilas, Walworth, Waushara or Winnebago Counties, you must report your accident or injury case to:

   Office of the Commissioner of Insurance
   Bureau of Market Regulation
   PO Box 7873
   Madison WI 53707-7873
   1-800-236-8517

OR

2. All other members should report to the agency before the case is settled by:

- Phone: (608) 221-4746 ext. 80062
- Fax: (608) 221-4567

BASIC PLAN RULES

Reporting Changes

While you are on the Basic Plan, contact Basic Customer Services, if you:

- Become disabled,
- Have children under 19 move into your home or become pregnant,
- Turn age 65,
- Move out of Wisconsin,
- Become eligible for Medicare,
- Get coverage through a private health insurance plan, or
- Have income over the program limits (200% of the Federal Poverty Level) (FPL). These amounts can be found at dhs.wi.gov/badgercareplus/fpl.htm.

If you no longer meet the rules for the BadgerCare Plus Core Plan for any of the reasons above, your Basic Plan coverage will end.

You can report changes by calling Basic Customer Services or online at access.wi.gov.

If you do not report a change, you may be required to repay the cost of benefits you should not have received or prosecuted for fraud.

Depending on what the change is, you may be able to enroll in a different plan.

Proof/Verification

Your Social Security Number (SSN) will be used to verify income and health insurance information you provide. This is done through computer checks with government agencies and other sources such as employers and health insurance carriers. You may be asked to provide proof of your income and health insurance information, if the information we have is not the same as you report.

Recovery of Benefits/Fraud

The Department of Health Services may recover any payments made on behalf of a member who:

- Intentionally gave false or incomplete information on the application for health care.
- Did not report a change that caused the member to get coverage s/he should not get.
- Uses another person's card to get services.
- Let someone else use his/her ForwardHealth card to get health care services or prescription drugs.

YOUR RIGHTS

All people enrolled in or applying for the BadgerCare Plus Basic Plan are protected from discrimination on the basis of race, color, national origin, sex, age, or disability.

To file a discrimination complaint, write to:

Wisconsin Department of Health Services
Affirmative Action and Civil Rights Office
1 W. Wilson St., Room 555
P O Box 7850
Madison, WI 53707-7850

Or, call: (608) 266-9372 (Voice)
1-888-701-1251 (TTY)

Or fax: (608) 267-2147

Review of Coverage Denial or Ended

If your enrollment in the Basic Plan is denied or ends, you may request that the Department of Health Services review the action by sending a written request to Basic Customer Services. Your request must be received within 60 days after the coverage is denied or ends. You must follow this process before you can take any action in court.

Send your request for review to:

Basic Customer Services
P.O. Box 7190
Madison, WI 53707-7190

Enrollment LETTERS

You will receive letters about your enrollment. You will receive a letter before you have a change in your enrollment. You should read each letter you get.

Understanding Your Notices

Notices you get for the Basic Plan will be in the same format. The following will be on your notices:

Summary
This page gives a short review of your case as well as what benefits you will get. You can also find the contact information for your agency.

Benefit Details
This page will give you detailed information about your benefits such as who is not and who is enrolled and the dates enrolled. If you are not enrolled; the reason(s) you are not. If you are able to enroll in other programs such as FoodShare, you will get a separate Benefit Details section for each program.

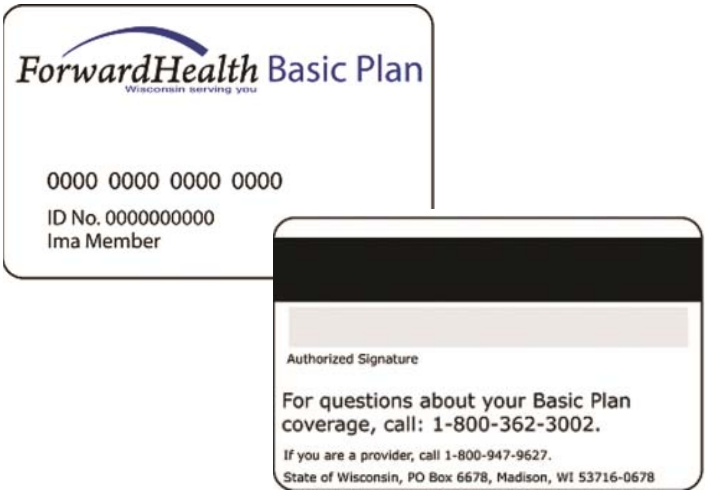
Household Income
This section lists the income on file for your case. You should check your notices to make sure all income is listed.

Your Reporting Rules
This page has your reporting rules, which tell you what changes need to be reported.

Key Contacts
This page has your key contacts. The key contacts give you information about who to contact with questions. You can also get the phone number from the back of your ForwardHealth Basic Plan card.

FORWARDHEALTH BASIC PLAN CARD

Everyone enrolled in the Basic Plan will get a Forward-Health Basic Plan card.



Call Basic Customer Services at 1-800-291-2002, if:

- Your name or identification number is wrong, or
- You have a question about your enrollment.

Call Member Services at 1-800-362-3002, if:

- Your card is lost, stolen or damaged,
- You have questions about how to use your card, or
- You have general questions about the Basic Plan.

Request a New Card

You can request a new card online at access.wi.gov or by calling Member Services at 1-800-362-3002.

Using Your Card

Take Your Card! When you go to your health care provider, take your card. Providers do not have to see you, if you do not have your card, or you may be asked to pay for the services.

Keep your card! Even if you get a notice saying your enrollment is ending. You will use this card if you enroll in the Basic Plan again in the future.

If you have a medical emergency and you do not have your ForwardHealth card with you, give your ForwardHealth number to all providers as soon as possible.

BASIC PLAN BENEFITS

Basic Plan covered services may change. You should always check with your health care provider to see if the service you need is covered, if there are any limits and if you will have a copay. The following pages list the Basic Plan covered services, limits for the service and the cost or copay for the service. Please keep in mind, health care providers could deny services, if you do not pay your copay.

Please Note: Physician (including Psychiatrist and Ophthalmologist), Nurse Practitioner, Physician Assistant, Podiatrist, Chiropractor and Optometrist visits all count towards the combined 10 visit limit per enrollment year.

Covered Services	Limits	Copays
Physician Services (includes Physician, Psychiatrist, Ophthalmologist), Nurse Practitioner, Physician Assistant, Chiropractor, Podiatrist and Optometrist		
Office Visits —Services include: • Primary and preventive care • Specialists • Surgical and medical services • Laboratory and radiology (including mammograms)	Services are limited to a combined 10 visits per enrollment year. Laboratory and radiology are not included in this limit. Drugs administered by doctors are not covered.	$10 copay per visit. All vaccines, including the flu shot, will have a $10 copay per vaccine. Radiology will have a copay of $5 to $20 per services. The amount depend on the type of service.
Drugs		
Generic only drug benefit with a few generic over the county drugs Preferred brand insulins (Humalog, Humalog Mix, Lantus, Tamiflu and Relenza are the only exception to generic and will be covered) Also includes drugs to help quit smoking.	Limited to 10 prescriptions per calendar month. Opioid drugs are limited to 5 prescriptions per month	Up to $5 per prescription. $10 copay for brand name covered drugs
Please Note: Basic Plan members will be automatically enrolled in the BadgerRx Gold plan. This is a separate program administered by Navitus, which may pay for drugs not covered by the Basic Plan. For more information about this plan, go to badgerrxgold.com or contact a Customer Care Specialist at 1-866-809-9382.		
Hospital Services		
Inpatient One inpatient stay with authorization.	Full coverage for one stay with authorization. **Note:** Inpatient psychiatric stays in a psychiatric ward, an acute care hospital, rehabilitation hospital or an Institution for Mental Disease are not covered.	$100 copay per covered stay. A $7,500 deductible will need to be met to receive additional covered hospital services (including inpatient stays).
Outpatient Full coverage with authorization	5 out-patient (non-emergency room) visits per enrollment year with authorization. Deductible after 5 visits	First 5 visits will have a $60 copay per visit. A deductible of $7,500 will need to be met to receive additional covered hospital services. Inpatient services can be used to meet the deductible.
Emergency Room Full coverage	2 Emergency Room visits per enrollment year	$60 copay per visit (waived if you are admitted to hospital)
Dental - Emergency		
	Coverage is limited to certain emergency dental services	$10 copays per visit
Covered	Limited to emergency transportation by ambulance	No copay

Covered Services	Limits	Copays
Ambulatory Surgery Centers (ASC)		
Coverage of certain surgical procedures and related lab services	Limited to 5 visits per enrollment year	$60 copay per visit
****Chiropractic Services***		
Full coverage	Services are limited to a combined 10 visits per enrollment year. Covered under "Physician Services" 10 professional visits.	$10 copay per visit
Disposable Medical Supplies (DMS)		
Coverage of diabetic supplies, ostomy supplies and DMS that are required with the use of a DME item.		Up to a $5 copay per item. $0.50 copay for diabetic supplies
Durable Medical Equipment (DME)		
Full coverage Note: Rental items are not subject to copays but do count toward $500 annual limit.	Up to $500 per year	Up to $10 copay per item
End Stage Renal Disease (ESRD)		
Full coverage		$10 copay per visit.
Hospice Services		
Full coverage		No copay
Therapy: Physical, Occupational and Speech		
Physical Therapy (PT) Occupational Therapy (OT) Speech Language Pathology (SLP)	10 visits per therapy type per enrollment year. (Cardiac rehabilitation services count toward the 10 visit limit for PT).	$10 copay per visit.
****Podiatry Services***		
Full coverage	Services are limited to a combined 10 visit limit per enrollment year. Covered under 'Physician Services 10 professional visits.	$10 copay per visit.
Family Planning Services		
Covered.	Family planning services provided by a family planning clinic are covered under Family Planning Only Services.	

Services Not Covered

The following services are not covered under the Basic Plan:

- Non-emergency dental
- Hearing Services and hearing aids
- Home Care Services (Home Health, Private Duty Nursing and Personal Care)
- Inpatient and Outpatient Mental Health and Substance Abuse Treatment
- Nursing Home Services
- Pregnancy - Labor and Delivery/Prenatal Care Coordination
- Transplants
- Transportation - Non-emergency
- Vision Services - Routine Services

AUTHORIZED SERVICES

Some services must be approved or authorized by the Basic Plan before you can get them.

Your provider asks for the approval for these services from the Basic Plan. If your provider does not get the service approved, the Basic Plan will not pay for the service.

BILLS FOR SERVICES NOT COVERED

If you request a service that is not covered and your provider tells you before the service is provided, you will be required to pay for the service. Your provider may bill you their usual and customary charge for the service that is not covered.

Department of Health Services
Division of Health Care Access and Accountability

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